



Member Notice – Confidential Communication of Medical Information

California law obligates health insurers to honor a Confidential Communications Request (CCR) when the CCR requests that “sensitive services” information, as defined by law, be kept from the primary subscriber. Under California law, when a CCR is submitted, health insurers must send communications directly to the health plan member and not the primary subscriber.

A protected individual, who is health plan member covered by this Policy, may submit a written request to the Company to direct communications regarding sensitive services to an alternate mailing address, email address, or telephone number.

How to submit a CCR request

Complete the CA Confidential Communications Request form and mail to

UnitedHealthcare Student Resources
P.O. Box 31201
Salt Lake City, Utah 84131

If you have questions or need additional information you can contact the Company at
800-767-0700



CA Confidential Communication Request

Name: _____

Address: _____

Telephone: _____

E-mail: _____

SRID Number: _____

Your relationship to student:

Describe the protected health information you want to make subject to confidential communication.

Please identify the alternate means or the alternate location you wish information to be communicated with you.

I request that communication about my protected health information be sent by the alternative means or to the alternative location. I further understand this request shall be valid until I submit a revocation of the request, a new confidential communication request is submitted or through the end of the coverage period.

Signature: _____

Date: _____

If this request is made by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____ Date: _____

To be completed by Privacy Official

_____ This request sufficiently satisfies the criteria.

_____ This request fails the criteria.

The affected business units and business associates will be notified to use alternative means or location to communicate protected health information within the required time frame.

I attest that the above information is correct.

Signature: _____

Date: _____

Print name: _____

Title: _____